ealth in Development Series

An Informal Consultation with Selected Development Partners

Geneva, 7-8 September 1999

Health in Development Series

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n Sustainable Development (HSD)

HEALTH AND POVERTY REDUCTION

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Summary Report

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SUMMARY REPORT

I. Overview, Major Outcomes, and Key Issues

An informal consultation was organized by the Health in Sustainable Development (HSD) department of WHO to discuss with selected development partners issues related to the role and contribution of health towards poverty reduction. The meeting was designed to gain a better understanding of views, frameworks, action plans, and lessons that can guide the development of an overall WHO policy on health and poverty reduction, as well as HSD's strategies. The meeting is one in a series that will obtain input into the WHO policy by a wide range of stakeholders in and outside the organization.

The meeting had four objectives:

1) to exchange views on how health can make a contribution to poverty reduction;

2) to review experiences of poverty reduction policies and strategies of participating development partners;

3) to discuss the process and challenge of institutional mainstreaming of poverty reduction, and the pros and cons of using "poverty" vs. "equity" as the basis for a strategy framework; and

4) to identify issues and areas for further collaboration and research.

The genesis of the meeting was HSD's belief that WHO's approach to poverty reduction should be consistent with those of other international development agencies, and build on new international co-operation frameworks that are currently under serious consideration. Examples include:

- The concept of sustainable livelihoods is steering poverty reduction approaches through its focus on the assets and capabilities of the poor to use their resources to reduce vulnerability.

- Globalisation forces are changing formerly private goods into international public goods; the determinants of health especially of the poor, for example, are increasingly global and so require new forms of global co-operation to address them.

- Concerning international aid, new ways of bringing together all elements of development - social, structural, human, governance, environmental, economic, and financial - are being tested, as are new methods of involving all stakeholders and ensuring that countries "own" the development agenda.

The premise of the meeting was that WHO must better understand the implications of these developments in order to define its own policy and approach to poverty reduction. In brief, there were five key issues that emerged from the meeting, which are most relevant to the development of WHO policy and HSD strategies:

- **The Role of Health in the Poverty Reduction Agenda**

The international development community has adopted a broad definition of poverty, which recognises that it is multi-dimensional in its causes as well as its cures. Since this definition views poor health as a contributor to poverty and good health status as a means to prevent poverty or offer a means out of it, health can be considered to be already on the international poverty reduction agenda. This is also clear from several recent developments: the inclusion of health-specific targets in the OECD's International Development Goals, consideration of health spending in the "20:20" investment targets of the Copenhagen 1995 Social Summit, and World Bank and IMF interest in working closely with WHO on the role of the health sector in development.

Yet, many argued that poverty reduction is not yet on the health sector's agenda. It was strongly urged that WHO view the inclusion of health targets in the international development goals (IDGs) as an invitation to strengthen the contribution of health in achieving the overall poverty reduction target (halving extreme poverty by 2015). The IDGs may offer a framework in which to unify a health agenda containing multiple strategies that go beyond the delivery of health services. Since poverty contributes to ill health, and health care is only one determinant of health status, it is clear that WHO should be working closely with other sectors in order to reduce poverty and to improve health outcomes. But doing so implies a broader set of strategies than have traditionally been used by the health sector.

There was some debate on whether WHO's overall goal should focus on: 1) improving the health status of the poor(est)1 or 2) reducing health inequities. Each had proponents, but it was agreed that the two concepts remain linked and they reinforce each other, i.e. analyses of differences in health between the rich and poor are more likely to stimulate action on behalf of the poor. Thus, participants welcome WHO's efforts to develop global and country-level health indicators on both the level *and distribution* of health outcomes. If one must choose between reducing poverty or improving equity, it should depend on each country's political and economic context.

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[1] This meeting focused on the poor in low-income countries, which is the primary concern for development assistance agencies. However, this is likely to be only one aspect of WHO's policy on health and poverty, given WHO's concern for the health consequences of those who are relatively poor in middle and upper-income countries.

- **Health Sector Strategies in the Poverty Reduction Agenda**

Four types of health sector strategies were discussed as contributing to poverty reduction:

1) a minimum set of health service interventions that addresses the major causes of illness among the poor (the so-called "package of packages");

2) improvements in health systems which will permit cost-effective use of limited resources, assure that services are responsive to the poor's needs, and offer protection against the financial burden of illness;

3) broad public health and health promotion approaches, such as safe water, clean sanitation, and healthy behaviours; and

4) creating an enabling environment by addressing the broader determinants of health such as education, opportunities for work and income, adequate food, and social and political integration of the poor.[2]

The discussions at this meeting did not go into detail on specific issues or activities within the four strategies. Efforts are underway to further define the "packages" approach and to clarify how it might be applied in various contexts or programs. Dr Shepherd's paper will also expand on some of the pro-poor health targeting approaches and avenues for health involvement in affecting the broader determinants of health.

Which of the four should WHO focus on? There was recurring discussion about which one, or which combination, best suited the strengths of the health sector generally and WHO in particular. If WHO focuses too heavily on the first set ("packages" of interventions for the poor), it will miss important opportunities to influence other determinants of health. Furthermore, WHO and its member countries will have to justify targeting of the poor with such services at the same time WHO and many countries are on record as committed to assuring access to health services for all (including the middle class). Most participants believed there should be a balance among the four strategies, though limits on resources may mean that priorities be set.

- **Development Cooperation Partnerships**

The meeting revealed a number of areas that hold great potential for WHO to work more closely with its development partners in linking health to poverty reduction. In any of the strategies WHO chooses, to be a credible and valued team player in poverty reduction with others in the international community, WHO and the health sector must base their approach on:

1) recognition of the multi-dimensional causes and cures of poverty;

2) intersectoral collaboration; and

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[2] Perhaps using a term other than "intersectoral action", in view of the "baggage" associated with it.

3) use of participatory approaches to policy development and program design. Other organizations that have tried to mainstream these approaches have learned that it requires commitment at the highest levels and explicit staff incentives. Specific areas for collaboration include;

a) WHO's EAS work elucidating the relationships between health and income growth might provide input into the World Bank's WDR 2000 work on institutional approaches to health equity and poverty reduction;

b) OECD-DAC will seek input on its operational guidelines on poverty reduction;

c) the EU will seek WHO participation in upcoming meetings to strengthen links between health and poverty reduction strategies and to set priorities in health;

d) DFID will be seeking comments and input from a wide range of groups on its health sector strategy towards poverty reduction;

e) collaboration with UNRISD in developing a research agenda in specific countries on health, poverty and social policies; and,

f) WHO may help to plan and co-sponsor a proposed World Bank international conference on poverty and health in the year 2001.

g) Also, an annual meeting on health and poverty reduction among major development partners may be held to ensure ongoing exchange of ideas, strategies, and progress.

- **Context and Capacity Building at the Country Level**

Those involved in poverty reduction strongly believe that to be successful, policies and strategies must be nationally owned and be adapted to the local context. There should be no pre-ordained position or policy on how best to "marry" health with poverty reduction, but rather countries must be exposed to a wide range of ideas, options, and tools. Ownership and local adaptation of policies depend on broad participation across society in policy development and program design. Strengthened government capabilities via capacity development is needed for these processes to occur. Few research programs, whether in collection and analysis of mortality data or monitoring health inequity, involve developing country institutions as real partners. This must change to be relevant to country context. Also, research must be tied more closely to advocacy so that the results of research feed into the policy development process. In addition, WHO was urged to focus its efforts to develop national capacity on research, planning and evaluation tools that countries can use to build in health indicators and questions to poverty assessments, monitor expenditures and service use in public and private sectors, track health outcomes, and assess other program impacts.

- **Research Agenda**

While it is widely recognised that improving health is an important means to achieve economic, social and human development, the economic case in favour of putting health at the very top of the development agenda is not strong at present. As mentioned repeatedly, the economic evidence that better health leads to higher income at the individual or household level is largely lacking or inconsistent. It was agreed that evidence to prove cause-and-effect would strengthen the economic argument in favour of putting health at the core of development and/or raise its priority within national poverty reduction policies. Many also believed that research on the effectiveness of health interventions on poverty reduction in different settings was equally important. In this context, there were three sets of research questions that could/should be pursued with WHO's support:

1. ***Links between health and economic development or income growth.*** Do countries that invest more in health have faster or more sustainable growth? Does improved health of the poor lead to increased household income, and if so, how much? Conversely, how much does income growth contribute to better health outcomes among the poor? Which set of micro-economic forces exert more influence on the health outcomes of the poor - financial barriers to health care or income lost due to work days missed? What are the links between globalisation forces, poverty and health?

2. ***Financing and targeting of the most important health services to the poor.*** Even if a cost-effective set of minimum interventions focused on the main health problems of the poor is developed, it will probably cost more than many low-income countries can afford. How can such countries raise the resources needed to implement such a package? What health system or political changes are necessary for effective targeting of the interventions to the poor? Which is more effective in reducing poverty - disease-based or special population-based targeting of health services? If the poor rely heavily on the private sector for care, should this be discouraged, or can private sector resources be steered or regulated by States to be more responsive to the poor? What training do health workers need to be more responsive to the poor and which incentives are effective in recruiting and retaining health professionals to serve the poor?

3. ***Broader determinants of health.*** Are there non-health service interventions that have a sizeable or cost-effective impact on the health outcomes of the poor? To what extent have health programs working alongside broad social development and poverty reduction programs, helped to reduce poverty or increase income? Could the health of the poor be improved substantially by preventing major industrial and environmental pollution that often results from economic development? Are occupational safety and health programs beneficial to large segments of the poor, and if so, what models can be identified? What is the poor's willingness and ability to pay for a combination of health-promoting services (e.g. water, sanitation, health services), rather than just one alone? Case studies of country poverty reduction and health sector policies may provide quicker and more credible evidence of health's contribution to poverty reduction, than large data collection and lengthy analysis, according to some participants.

Section II of this report, which follows, summarises the discussions and presentations in the four topics that correspond to the meeting's major objectives. Section II also contains

specific ideas and suggestions that may be considered in developing WHO's overall policy on health and poverty reduction.

II. *Summary of Discussions*

A. How Can Health Contribute to Poverty Reduction?

Four presentations offered a diverse set of perspectives on health's relationship to poverty reduction. These perspectives, representing various disciplines, beliefs and approaches, suggest that there might a number of new ideas, action strategies, research agendas, etc, that complement each other in WHO's policy on health and poverty. On the other hand, their differences imply the need to reconcile some conflicts, and/or to establish some priorities among the four major strategies, given resource limitations at both WHO and country-level.

Dean Jamison, Economics Advisory Service (EAS), WHO
EAS is working to clarify the linkages between health and poverty in two respects:

1) the link between health and income growth, both at the macro and micro-level, which will involve re-analysis of some previous data; and

2) identify appropriate health sector responses to the health conditions of the poor.

With regard to the first, five major factors were all thought to be inter-related: reduced fertility, physical development, cognitive development, improved health, and income growth among the poor, as reflected in the 1980 World Development Report. The WDR asserted that the role of primary education in fostering cognitive development was the key to a "virtuous" and beneficially reinforcing set of dynamics. The question now is whether improved health could be the key input that stimulates improvements in each of the other four factors. This view still acknowledges that the other four are also influenced by their own sector-specific strategies, e.g. food policy on physical development, family planning programs on fertility, poor-friendly macroeconomic policy on income growth, and education on cognitive development. Jeffrey Sachs, of Harvard University, will chair a Commission on Macroeconomics and Health that will review the literature and oversee analytic work to see if a "health-led" approach to economic development is justified.

The composition of a "health-led" approach, or the set of appropriate policy tools, forms the basis for the second line of work by EAS. Of three possible approaches - which he defined as intersectoral, broad health system strategies, and focused health intervention strategies - EAS believes WHO can make the most difference via the third one. EAS in conjunction with others in WHO will try to assemble a "package of packages", which would include the most cost-effective interventions targeted to the most prevalent diseases of the poor, e.g. AIDS, TB, respiratory diseases of children, measles and other vaccine preventable diseases and malaria. While such packages have been tested and proven effective in each of these areas, there has been little co-ordination among them and insufficient attention to the health system features needed for their delivery. The "minimum set of interventions" aims to address these problems.

Pamela Hartigan, Health Promotion (HPR), WHO
The perception of health promotion is often considered narrowly as the prevention and reduction of chronic diseases, conducted through general educational campaigns and preventive health services delivered to individuals. This perception has been reinforced by much of WHO's health promotion work in the past, which has focussed on developed countries. However, based largely on the 1988 Ottawa Charter for Health Promotion, the field of health promotion has a considerably broader view of the strategies that must be used to *promote health.* What is relevant to the area of poverty reduction is the view that health promotion must address the social enabling conditions for health. This forms the core of health promotion's use of the "settings approach", e.g. Healthy Cities, Islands, Workplaces, Schools. Such approaches are comprehensive, encompassing services, education, behaviours, and environmental factors needed to improve health. They have led to greater knowledge about the complex web of social determinants of health and the nexus between health and poverty. They also have been highly effective in stimulating action on problems and issues that matter most to people in communities. WHO's Health Promotion unit is committed to collaborating with other WHO departments to further evaluate the relationships between social determinants of health and social capital as it relates to poverty, to shape multidisciplinary conceptual frameworks, and to recommend both process and outcome indicators to assess the effectiveness of health and poverty reduction strategies.

Chris Murray, Global Program on Evidence for Policy (GPE), WHO
The GPE department is currently involved in a number of activities that will enhance WHO's ability to evaluate and compare how well country health systems are performing, shown in international league tables. The Evidence and Information for Policy cluster has proposed that health systems be assessed based on their achievement of three primary goals: improved health status, responsiveness to public expectations, and protection against the financial consequences of illness. Within each of these broad goals, specific objectives will be specified that can be measured based on both a) the average level in each country's population, and b) the distribution across segments of the population. The set of measures regarding the distribution of health status, public responsiveness, and financial protection should be of greatest relevance to WHO's work on poverty and health. Data collected from countries on a regular basis will show the extent of health inequalities within their population. However, to be useful as a policy tool, this work must be combined with analysis of which health system design characteristics affect performance on the goals. Thus, some key health system functions will be measured and examined to see how they relate to the three goals. Such knowledge could help to elucidate how health systems can be organised and financed to benefit the poor.

Andrew Shepherd, School of Public Policy, University of Birmingham, UK
This presentation reviewed a paper in progress, commissioned by HSD, which seeks to place health within the realm of poverty reduction policies and programs. As this paper is available as a separate HSD document, only the main conclusions are highlighted. The evidence about health interventions' impact on poverty reduction remains sketchy. "The international comparative evidence is missing to put health on a level with education as a driver of poverty reduction", he said. But the sustainable livelihood framework suggests that good health status contribute to poverty reduction through:

a) *income* (e.g. employability, increased productivity);
b) *assets* (savings protected and protection against risk);

c) *human capital* (e.g. ability to learn, increased well-being and security); and
d) *social capital* (increase in social solidarity, women engaged through their health concerns and responsibilities).

So, for example, good health allows family breadwinners to work and prevents spending of household income or the disposal of assets that would otherwise be spent on costly health care. If one looks at health as a means to advance sustainable livelihoods, there may be new implications for health policy and practice.

Because health outcomes reflect other factors (e.g., income, education, social capital, status of women and fertility rates), "health status measures can be a very useful indicators to monitor the reduction of poverty, when conceived as a multi-dimensional phenomenon". There remains much room for the health system to make services more accessible and relevant to the poor, and the paper includes a pro-poor health checklist. Finally, potential avenues for expanded health sector involvement in poverty reduction programs were divided into several arenas:

1) macroeconomic policy and governance;
2) health sector-level reforms;
3) more direct linkages between health and "livelihood" programs targeted at the poor and vulnerable; and
4) health's involvement in building social and political capital of the poor.

Discussants

Monica Das Gupta, World Development Report, World Bank, emphasised high-level interest in integrating health and poverty reduction at the Bank, building on previous work by Davidson Gwatkin, Jeff Hammer and others. There is always room for better integration of multi-sector work, she said, and if health can be the impetus for it, so much the better. From her own experience, she believed that the synergies are not as obvious as they might seem. Safe water and improved sanitation at the household level does not necessarily reduce infant mortality; a minimum number of households must be covered for this to occur. Turning to the World Development Report 2000, which will focus on poverty, she said it would explain what has changed since 1990 when the last poverty-focused WDR was issued, such as the importance of political economy to policy making. There will be three major themes:

1) empowerment issues related to state institutions, decentralisation, and governance;

2) sharing of risk and opportunity (health message not defined yet); and

3) globalisation, in which further issues for R & D will be spelled out. The health components of the report are planned to include institutional approaches to improve equity and poverty reduction. It will also discuss incentive structures in service delivery and financing. And, it will focus on "inclusive health strategies" that generate demand for health promotion and maintenance.

T. Mkandawire, United Nations Research Institute for Social Development (UNRISD), believed that like WHO, many institutions were rethinking their value and relationship to economic and

social development, apart from their own intrinsic value. In this process, however, it is important to keep in mind resource distribution issues, given their politically controversial nature. Likewise, it is important to know who is active and interested in these issues at the national level. Health is part of most country's national policy debates, but as few know how they compare with others, the international comparisons in WHO's Year 2000 Annual Report will be valuable additions. They might even spark such debates in countries that have not adequately addressed health issues. In any country, there are some key questions that should be addressed to make progress:

1) who makes policy?
2) by whom should services be delivered - the market or the state? and
3) how do the poor organise themselves to gain access to health services?

Finally, any new approaches to health in the context of poverty reduction will require close collaboration between national policy makers and donors, especially in Africa. Many national institutions are in disarray, policy makers are discredited if they talk about equity, and state capacity is often undermined.

G. Paulson, Swedish International Development Assistance, admitted that SIDA's 1996 poverty program, which outlined strategies in democracy, environment and equality/gender, was not well co-ordinated. Thus, a new process has begun to revise poverty reduction programming, with a view towards integrating health into an overall development strategy. SIDA believes that equity and human rights must be part of the poverty reduction agenda, as well as health sector reform. Progress towards health status improvements and health equity requires that health be placed higher on the political agenda. Among the key research issues he identified: understanding why there are growing inequalities in countries with economic growth; links between globalisation, poverty and health, and public-private mix of providers.

Discussion

Health's (and WHO's) contribution to poverty reduction. Nearly all participants recognised the importance of ensuring that the health sector, on its own and in conjunction with other sectors, contributes to improved health outcomes among the poor. But should WHO concentrate on better targeting of health services to the poor? Or are other strategies equally important? Expanding its focus beyond health services has a severe practical limitation: the large amounts of resources spent on curative, personal health services restricts the ability of most Ministries of Health to invest elsewhere or to work with other sectors. Indeed, if WHO promoted a minimum set of interventions for the poor ("packages"), it might exacerbate this problem. Still, things that require little time or resources of health ministries can be strongly supported by them, e.g. non-health sector investments that are critical to the health of the poor such as nutritional supplementation. One person even suggested that if "health packages" were to become the core of WHO's approach, two other packages should be designed as well: a multi-sectoral package, in which health is bundled with education and nutritional programs, and an inter-sectoral package in which health is part of an overall development strategy. This last package would depend on making a case to the other sectors that health is an important instrument of development.

Adapting policy making/program design to the needs of the poor. Comments stressed the importance of building into health and poverty reduction programs a greater

understanding and recognition of the reality of poor people's lives. Knowing better when, how, and where the poor seek health services is critical information for policy and program design, especially in the control of communicable diseases. Consideration of the poor's capabilities and those of their extended networks should also be built into policy design.

Research gaps/study needs. Many people noted the poor's heavy reliance and disproportionate spending on private sector services. While several people believed that more study is needed on what is influencing the poor's demand for private services, others attributed it to poor quality, inadequate public health services, insufficient or insensitive health workers, etc. Use of traditional medicine may be growing because of this, but also because it is often less expensive than either formal public or private health services. The issue needs further study, as the expenses keep the poor in poverty or impoverish those who become very ill. Another question that might be examined is which has a stronger effect on keeping people in poverty: health care expenses or the loss of work due to illness. The answer could steer policy priorities of the health sector.

B. Role of Health on the Poverty Reduction Agendas of Development Partners

This segment of the meeting focused on how health fits into the broader poverty reduction agenda of development partners. The presentations and discussion showed that health is very much part of the overall development strategy of all participating development agencies, though the specific strategies are currently being revised or getting more focused. Generally, these revisions promise to strengthen the links between health and poverty reduction programs, so that health is more clearly contributing towards the achievement of the International Development Goals and targets. At the same time, development partners emphasised the need for stronger international co-operation and co-ordination to reach these targets, to ensuring national ownership of poverty reduction strategies, and to participatory approaches and gender dimensions of poverty.

Lieve Fransen, European Commission, reviewed the EU's previous poverty reduction strategy, which focused on support to social sectors, sustainable growth, and safety nets. Poverty itself was often defined in monetary terms only. Currently, spending on social services reaches 20% to 25% of total financial EC commitments, with HIV/AIDS, health and population representing about 10% of the total. Thus, the EC is meeting the 20:20 target set in 1995. More recently, the EC, with several of its partners, has redefined poverty in a more multi-dimensional manner and increased attention is given to the dimension of vulnerability, enabling livelihoods and risk as related to poverty. In parallel to this evolution, the EC's policy on Health, HIV/AIDS and Population (HAP) has evolved towards a sectoral approach where the main focus goes to sound and efficient management of public funds, co-ordination between all donors and provision of basic services. In the future, a three pillar approach to Health is proposed around 1) the macro-level and the multi-sectoral approach, 2) the sectoral approach and 3) the generation of knowledge and capacity building. Institutionally, in the internal reorganisation of the Directorate for Development, a social and human development unit was created, which is in charge of poverty reduction policies and strategies. Though discussions on Health and Poverty are not yet finalised, some of the strategic directions are already clear, namely a greater attention to outcomes rather than inputs and monitoring of those outcomes in relation to poverty status. In

addition, there will be efforts to operationalise the participatory approach in poverty assessments and country strategies, as well as in sectoral policies. This would allow people to become agents of change and not merely patients.

Arjan de Haan, Social Development, UK Department for International Development, stressed that health is on the poverty agenda, as four health goals were explicitly included in the international development targets (maternal mortality, infant mortality, universal access to reproductive health care, and HIV). However, the health sector needs to be more integrated into poverty reduction frameworks. In particular, health needs to be more responsive to poverty issues and think in inter-sectoral frameworks. The health sector can become more integrated if it embraces four key principles:

1) Adopt the multidimensional definition of poverty, in which poor health status and lack of health care access is but one of many deprivations. Indeed, such health problems often go hand in hand with other "lacks", such as income, assets, education, and social & political participation.

2) Allow/encourage more participation of the poor in health care decision-making, by involving them in assessments of their own priority problems and solutions.

3) Consideration of the "sustainable livelihoods" framework to help put people at the centre of development by focusing on their capabilities in the assets or basic building blocks needed, defined as financial, physical, human, natural and social capital (a set of Guidance Sheets produced by DFID explain these in more details and the sustainable livelihoods framework more generally). Thinking about health development in this framework might help to improve its effectiveness in reducing poverty, he said.

4) Broaden its view to include avenues for promoting human rights (civil, cultural, and political) among the poor. For example, the health sector could support human rights organizations, help secure access to information, and help the poor obtain justice.

Bjorn Wold, Statistics Norway and NORAD Consultant, discussed NORAD's poverty reduction programs and challenges. Based on the Copenhagen Social Summit and its 20:20 investment goal, NORAD has attempted to reach the poor by focusing on the poorest countries and within them, on the poorest groups. A Social Sector Initiative has featured efforts to better track and monitor investments on social services, including health. A conceptual framework for poverty reduction views health as a right, rather than something to leave to the "safety net", and recognises the importance of public control in directing private sector initiatives towards social goals. But there are several challenges to better integrating poverty reduction with health sector programs. First, it is much harder to reach the poorest with health services. Second it is difficult to prove that improved health status will reduce poverty via increasing income at the individual level. The reverse is also true - higher income doesn't always lead to better health. For example, in Ghana, the upper fifth of the population in income still have very high infant mortality rates. There is also some evidence suggesting that malnutrition among rural children gets worse in the process economic development, before it improves. In addition, there are market failures in both the private health sectors, e.g. drug vendors selling cheap drugs, private clinics charging high prices, and government failures in the public health sector, e.g. bribes taken by public providers.

Discussion, focused around the following four themes:

The Place of Poverty Reduction and Health on the Development Agenda. The ascendance of poverty reduction to the centre of the international development agenda is clearly causing many donors to fundamentally rethink and reorient their funding priorities. There remain questions about whether health can become the highest priority in this new agenda. Health's low profile in the development agenda in the 1980s was because of the economic crisis and a neo-liberal ideology that said health could be left to private market forces, both of which reinforced the belief that high economic growth could "handle" poverty. These factors still represent a hurdle in bringing health to the core of social policies or the poverty reduction agenda. However, the rise of left-of-centre governments in Europe has helped to push poverty reduction to the top of the donor agenda. The Copenhagen Social Summit also helped by focusing donors on outcomes, rather than just inputs. That is not to say donor funds are not important; indeed, investments in health "don't come cheap" and must be made over a very long time to produce the desired outcomes or targets.

Country Priorities and Strategies on Poverty Reduction and Health. The biggest challenge in many cases is getting governments to own poverty reduction and health policies. Where poverty reduction is on any given country's agenda due to political forces (rather than donor-influence), it has always been on the agenda, according to one. If internal political forces are not supportive of placing poverty reduction high on the national agenda, donors have to be sensitive to these dynamics in their efforts to push a greater focus on the poor. This challenge was apparent in donor efforts to raise the visibility of gender issues. Donors must also be honest about their own shifts in priorities and explain why poverty reduction has become their focus again. In any case, experience seems to show that getting social issues higher on the political agenda requires pressure on governments from a broad set of groups - civil society and the media in particular. Many believed there was little co-ordination between health sector and poverty reduction policies, especially in Sub-Saharan African countries. For example, efficiency-inspired health sector reforms sometimes have had adverse effects on poor people.

Health in the human rights agenda. Some believed that the case for putting health higher on the development agenda should not rest on the results of more definitive research proving that health care contributes to poverty reduction via increased income - health care is important in and of itself. This is clearly recognised by the World Bank, the EC, and most bilateral donors. Many agreed that ideally, access to health care is a human right. In Latin America, health actions are part of a human rights and democracy agenda and this has been a useful advocacy platform, which might be a model elsewhere. But others argued that the notion means little in countries that cannot afford to pay for basic health care.

Intersectoral Action. While most believe in the value of intersectoral activities based on the synergies created toward poverty reduction, there were also some cautions. For example, safe water is usually much more politically popular than sanitation, making it hard to garner support for the latter. At the World Bank, poverty reduction specialists are anxious to involve the health sector and can contribute practical tools such as effective methods to target the poor. But health sector specialists (like many Ministries of Health) see poverty as yet one more burden or responsibility to add to an already very full agenda. Previous generations of poverty reduction programs, which focused on direct ways to increase income among the poor (e.g. micro credit, enhancing work skills), did not collaborate with health; the health sector may have lost an

opportunity that is hard to re-capture now. There is still much to be done in integrating macroeconomic policy with the social development agenda.

C. Mainstreaming Poverty Reduction in Development Cooperation: Health Implications

The objective of the third part of the meeting was to review institutional experiences in mainstreaming poverty reduction, in order to derive lessons for the health sector and for WHO. A presentation was made by an OECD representative, which recently completed a study on donors' poverty reduction policies and practices (the "Scoping Study"). Donor representatives offered their own observations on the reasons that poverty reduction has been more or less successfully mainstreamed within their own institutions, which are summarised below under factors promoting, or hindering, poverty reduction mainstreaming. Suggested strategies to mainstream poverty reduction or increase the impact of country poverty reduction programs are also noted.

Implications for health sector generally: On the one hand, the health sector in general faces an uphill battle in focusing more on the poor if national governments have not placed poverty reduction high on the political agenda. Efforts to force them to do so violate the principles of ownership and partnership that donors espouse. On the other hand, donor spending targets linked to poverty-reduction or targeting of the poor, and prospective monitoring of poverty impact offer good opportunities for re-orienting health sector strategies towards poverty reduction. In this regard, WHO's monitoring of country-level health indicators that focus on equity may be useful tools.

Implications for WHO: Though many donors are re-orienting their funds towards countries with good enabling environments (e.g. good governance), WHO may not be able to limit its activities to such countries. But could WHO steer more funds towards NGOs, as some donors have decided to do in such cases? If WHO wants to raise the visibility of health in the development community's poverty reduction agenda, one way to do so would be to make poverty reduction more central to WHO's own work. For this to occur, the lessons from other development agencies must be heeded (see list of factors, below). Others disagreed, saying all of WHO does not need to be focussed on poverty reduction, but rather it must emphasise the role that WHO can play in poverty reduction, especially at the country level.

Stephanie Baile, Development Cooperation Directorate, OECD-Development Assistance Committee, explained that DAC had been asked to develop guidelines in the next year to help steer donors' activities towards the ambitious goal of halving poverty reduction by 2015. An Informal Network of poverty reduction experts has been meeting to elaborate on how development agencies should fundamentally change their approaches to development, how to improve program implementation, and to identify which programs have high impact on poverty reduction. The Scoping Study's main conclusion was that so far, poverty reduction is longer on rhetoric than on impact. However, its review of donors' current poverty reduction programs led

it to conclude that OECD-DAC must form consensus on the definitions and measures of poverty by all member countries, that country assistance strategies remain important tools but require they require greater ownership and partnership among external and national groups, and that some key areas need strengthening at the country-level, such as:

a) good governance and empowerment of the poor;
b) principles and practices for targeting of the poor; and
c) sector-wide approaches as instruments for poverty reduction.

With regard to institutional change and mainstreaming, the Scoping Study identified three spheres for action: agency policies and procedures; agency country assistance strategies; and country-level dialogue. Four factors contribute to more effective mainstreaming, including staff incentives, organisational structure that facilitates multi-dimensional/cross-sectoral approaches, for example, the ability to integrate gender issues in all donor activities, and the existence of poverty-oriented monitoring, evaluation, and feedback systems. The report also recommends that poverty reduction impact should be used as a key criterion for screening and approval of donor projects. Finally, greater coherence must be forged between aid and non-aid aspects of relationships between donor and recipient countries. In the near-term, OECD will be writing the guidelines with recipient and partner countries, and in consultation with civil society groups in the first six months of the year 2000. (See Synthesis Report for further details. Chapter 1 of the draft guidelines will be sent to HSD for early review).

<u>Factors Promoting Poverty Reduction Mainstreaming in Donor Agencies</u>[3]

- commitment of Minister (or department head) to poverty reduction & international development goals;

- strong, visionary leader who requires each department head to define their own contribution to the overall goal of poverty reduction, and then holds them accountable for it;

- building on success of previous efforts to mainstream gender issues;

- review of poverty reduction impact at country level, rather than project level;

- active participation of all country/field offices in developing poverty reduction strategy;

- monitoring systems that track percentage of funds by sector, by degree of focus on poverty reduction (e.g. pro-poor enabling activities, targeted interventions for the poor), and by impact on poverty as measured by the international development goals at the country level);

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[3] UNRISD noted a relevant paper, reviewing the experience of World Bank, ILO, and other development agencies in the gender mainstreaming process, which suggests that mainstreaming of poverty reduction is more likely to succeed the more it reflects the real lives of poor people.

- higher priority/visibility of social sectors in relation to macro-economic adjustment policies.

Factors Hindering Poverty Reduction Mainstreaming in Donor Agencies

- lack of staff incentives, staff skills in both HQ and field offices;
- focus on sector work can prevent cross-sectoral approaches;
- health sector-wide lending, with its focus on the whole health system, can dilute attention to equity and poverty;
- training in poverty reduction is too general, so has low impact in absence of operational guidelines;
- lack of an overall donor poverty reduction strategy;
- quick development of donor poverty-reduction strategy by macro-economists, without broader participation;
- institutional inertia can thwart more or faster progress;
- lack of concern or commitment by governments to the poor;
- pressure to disburse funds quickly at end of fiscal year leads to hastily devised projects.

Strategies to Mainstream Poverty Reduction or Increase Impact in Countries

- country assistance strategy papers, developed in conjunction with recipient governments;
- institutional strategies for persuading or supporting other international agencies to strengthen their commitment to poverty reduction;
- sector-specific strategies that strengthen the focus on poverty reduction (e.g. DFID's Better Health for Poor People will cut across all sectors' contribution towards and impact on health), rather than project-specific;
- concentrate resources on fewer countries, e.g. the poorest countries or the poorest within countries as NORAD does, while recognising that this may take more resources still, or countries that have good enabling environments, as the Dutch DGIS does;
- focus on process of becoming or rising out of poverty;

- promoting national ownership of poverty reduction strategies (without sacrificing imperative to reach poorest of the poor as in NORAD's case). One way to do this is to strengthen country nationals' capacity to monitor/assess poverty, but this must be combined with a political strategy as well;

- disbursing funds, contingent on progress on agreed-upon performance indicators;

- using WB or UNDP poverty assessments to help target social/health programs to the poor.

D. Poverty Versus Equity?

Another objective of the meeting was to weigh the advantages of using a poverty reduction framework versus one that emphasises improving equity. The presentations and discussion made it evident that the poverty reduction and equity agendas converge and reinforce each other, more than they did divide. Despite previous studies, which showed that with economic growth, inequality rises, a growing consensus says that equality is good for economic growth. Because the poor contribute disproportionately to export production, economic growth relies on raising human capital, not just physical capital. Thus, the poor must have adequate health and education to contribute.

Davidson Gwatkin, Health, Nutrition and Population, World Bank, clarified the distinction between the two concepts. Poverty is concerned with the health of the poor, whether defined absolutely (e.g. those living on less than US $1 per day), or relative to others within each country. The OECD-DAC goal of reducing poverty is an absolute measure (reduce poverty by half), while many health goals are relative as they are based on national averages. Equity is concerned with health differences between poor and rich, which assumes that the differences are unjust and remediable. One can advocate improving the situation of the poor to redress inequities, however. Do the differences matter? No, in the sense that not all differences between groups are unjust, but instead may reflect social or cultural preferences. But yes, in the sense that the differences have important implications for resource allocation.

For example, if one were concerned with absolute poverty, one would direct all funds to South Asia and Sub-Saharan Africa. If one were concerned with relative poverty, one would invest in most countries, but target funds to the poor. If one is concerned with equity, areas with the greatest inequalities might be emphasised, such as Latin America. The World Bank is associated with the poverty approach, while the EC and WHO are more associated with health equity. His own view is that the differences are not trivial, but that they are minor compared with those who support general economic growth and efficiency as the primary development approach versus focusing on the poor or on inequity. Data from both perspectives - health of the poor and rich/poor differences - has been examined using DHS surveys in 50 countries. One sees very different patterns in health outcomes (attended delivery, immunisation, and antenatal care) depending on the country in question. For example in India, all three correspond to social class, but in Malawi, all are more evenly distributed across the population. In Peru, attended deliveries are unevenly distributed (correlated with income/class), while immunisation is more evenly distributed perhaps because of a national immunisation campaign. The two concepts remain

linked, he said, since analyses of the distribution of health outcomes are more likely to stimulate action on behalf of the poor.

M. Wijnroks, Social Policy Division, DGIS, The Hague, agreed that social inequality and poverty are inter-linked in the process of social development. Discussion of equity is new at DGIS and has prompted examination of data at the country level in evaluating policy options.

Hans Rosling, Karolinska Institutet, Sweden, presented two "Global Health Charts", which present in clear graphic form the relationship between child survival rates (up to 5 years) and GNP per capita. One chart highlights regional country groupings and the other highlights country-level fertility rates. The database has data going back to the start of the 20th century for some countries, which allows one to examine historical trends. In some countries, progress was made simultaneously in both child survival and GNP per capita. But in others, much more progress was made in improving child survival rates despite relatively little progress in GNP, suggesting targeted health, nutrition, or other interventions have made the difference. In contrast to Murray and others, Rosling advocates using total GNP as the comparison rather than total health spending since the latter only captures health *care* or health *system* spending (and even then it fails to capture much of private health care spending in developing countries), whereas total GNP captures many other factors that contribute to improved health outcomes (e.g. nutrition, education, income, etc.). This view underscores the importance of intersectoral policies to achieve health gains. He modified Murray's implied equation for health inputs into health outcomes to account for non-health sector factors. In one example, he added an equity factor, which one could test by measuring the share of total GNP/capita by the poorest 20%. In another he suggested that everything must be adjusted for "context". The formulas and two charts are available separately.

Tim Evans, Health Sciences, The Rockefeller Foundation, was an "equity" advocate, claiming that the distribution of health is as important, if not more so, than the level of health overall. He asserted that health systems and societies in general have a propensity to generate health inequities in ways that are poorly understood, and that health systems know little about how to enhance equity. Rockefeller is committed to strengthening equity, as a complement to the other two pillars of health systems - efficiency and quality. The central objective is to increase the capacity of global health systems to monitor and bring attention to health equity, understand its root causes, and develop equity-enhancing interventions. Specific strategies to address health inequity are related to their perceived causes. For instance, leadership training is done to help health systems to cope with the disruptive effects of decentralisation, financing reforms and fiscal cuts. Growing social inequity is tackled through the "sustainable livelihoods" approach, in which food, jobs, education, gender and democracy are addressed holistically. The Global Health Equity Project has conducted 12 country case studies to examine the determinants of health equity, which will be available shortly. He also shared results from a study in Bangladesh showing that membership in a micro credit program helped to explain improvements in female life expectancy, although much of the difference with the control group remains unexplained. He advocated more research to explore synergies between poverty alleviation programs and health services. [*Note:* A later comment qualified these results by noting that the data came from just the Metlab area in Bangladesh and that program participants received additional health services not normally received by the control group.]

Discussion focused on the pros and cons of focusing on the extreme poor. It was noted that if your goal is to improve health outcomes, it is easiest and most cost-effective to target the vast majority - the better off, and the poor and near poor - rather than the extreme poor for whom more is needed to reach them and improve their conditions. The "context" issue was raised in this regard; in some countries, poverty is concentrated in certain areas, in others in certain social groups. But if poverty is concentrated in the most remote regions, it will cost even more to get services to them. In terms of economic growth, it may make more sense not to focus on the poorest because the "demographic gift" of reduced fertility is more quickly produced among the majority population. China is an example of a country that has had high overall economic growth and poverty reduction. Would we downplay these results because its health inequity has increased? Clearly, there is no easy answer.

Proposed Agenda

Health and Poverty Reduction: an informal consultation with selected development partners

WHO Geneva, 7 and 8 September, 1999

PREAMBLE :

WHO is currently in the process of developing a WHO Policy on Health and Poverty reduction. The policy will be based on an organization wide framework in coherence with the emerging WHO Strategic Agenda. It will highlight the reciprocal relation between poverty and ill-health by addressing several dimensions which include: improving the health of poor and vulnerable populations by promoting an effective health dimension to social, economic and development policy including poverty reduction; identifying pro-active approaches for reaching poor and vulnerable populations; and targeting interventions towards the diseases of the poor.

Within this process, the specific role of HSD is to contribute towards the poverty reduction agenda by focusing on the health dimensions of poverty reduction, an area which has been largely missing from the debate, both at policy level and in practice. HSD has therefore a role to play in helping fill this void. In order to do this HSD needs to start a dialogue with agencies and institutions active in poverty reduction.

This informal consultation is the first in a series of meetings to learn and draw from the experiences of such organizations and agencies. The outcome of the consultation will contribute as one of the components, towards the overall WHO policy process.

Objectives of the Meeting

1) to exchange perspectives on how health can make a major contribution to poverty reduction;

2) to review existing experience and practices in poverty reduction policies, strategies and programmes, including the examples of programmes with health components

3) to review institutional experiences on approaches to equity and to poverty reduction and on change processes put in place to mainstream poverty reduction

4) to draw up a tentative list of policy and implementation issues which will require further consultation and research and define operational mechanisms for collaboration.

Tuesday 7 September 1999

8h30 – 8h45: Opening by
Ms Poonam Khetrapal Singh, Executive Director, WHO / SDE

Moderator: *Ms Eva Wallstam, Director, SDE / HSD*

8h45 – 9h00: Introduction by Eva Wallstam: Objectives and scope of the meeting and the role of HSD

9h00 – 10h30: Panel: **Health's contribution to poverty reduction (objective 1)**

presentations by:

EIP: Dr Dean Jamison
HSC/HPR: Dr Pamela Hartigan
(15 minutes each)

HSD: Dr John Martin
Dr Andrew Shepherd

10h30 – 10h45: Coffee break

10h45 – 12h:30 **Comments and responses**

World Bank / World Development Report:
Ms Monica Das Gupta

United Nations Research Institute for Social Development (UNRISD): Mr Thandika Mkandawire

Sida: Mr Göran Paulsson

(15 minutes each)

Plenary discussion :
Reflections and experiences from participants

12h30 – 14h00: Lunch

Moderator: *Mr Thandika Mkandawire, UNRISD, Director*

14h00 – 16h00: Panel: **Poverty reduction programmes : Why is health not on the agenda and what can be done ? (objective 2)**

presentations by:

European Commission: Dr Lieve Fransen
DFID: Mr Arjan de Haan
NORAD: Mr Björn K. Wold
(15 minutes each)

Plenary discussion

16h00 – 16h15: Coffee break

16h15 – 17h30: **Summing up key issues**

Report by "Listeners":

DFID: Dr Julian Lob-Levyt,
HSD: Ms Debra Lipson,

Plenary Discussion

18h00: Reception in the WHO restaurant

Wednesday 8 September 1999

Moderator: *Dr Eugenio Villar, WHO / HSD*

8h30 – 8h45: **Summary presentation of findings and conclusions of OECD/DAC study on institutional mainstreaming of poverty reduction. (objective 3):** Ms Stéphanie Baile, OECD

8h45 – 10h30: **Mainstreaming poverty reduction in development co-operation; lessons learned and implications for health:**

DFID
DGIS
European Commission
NORAD
OECD-DAC
Rockefeller Foundation
Sida
UNRISD
World Bank
(5 minutes each)

Plenary discussion

10h30 – 10h45: Coffee break

Moderator: *Ms Monica Das Gupta, World Bank, World Development Report*

10h45 – 12h30: Panel: **Poverty or equity; where do we focus ? (objective 3)**

presentations by:

World Bank / HNP: Dr Davidson Gwatkin
DGIS: Ms Mariki Wijnroks
Sida: Dr Hans Rosling
Rockefeller Foundation: Dr Timothy Evans
(15 minutes each)

Plenary discussion

12h30 – 14h00: Lunch

Moderator: *Dr Joe Kasonde, WHO/EURO*

14h00 – 15h00: **Identification of key issues and processes for future research (objective 4)**

Sida: Dr Hans Rosling

Discussion

15h00 – 16h30: **What next ? Areas for action and avenues for collaboration**

Plenary discussion

16h30 Closure

Annex 2

Health and Poverty Reduction: an informal consultation with selected development partners

WHO Geneva, 7 & 8 September, 1999
Salle M 505

List of participants

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	Ms Eva Wallstam, Director HSD HSD Staff	